

*Commonwealth of Massachusetts
Department of Mental Health*

TO BE FILED ONLY IN THE CONFIDENTIAL CORI FILE

***REQUEST FOR REPORT OF
CRIMINAL OFFENDER RECORD INFORMATION***

Client Name

Client AKA

Date of Birth

Social Security Number

I hereby request a report of Criminal Offender Record Information (CORI) relative to the above-referenced client. I request this report on behalf of _____, a facility of the Department of Mental Health.

Please contact me if you require additional information in order to fulfill this request.

Date

Signature

Name

Title

Business Address

Business Telephone

Business Fax #

**This completed form should be sent to:
Department of Mental Health
Forensic Division/CORI Request
25 Staniford Street
Boston, MA 02114**

**PATIENT CONSENT TO RELEASE OF
CRIMINAL OFFENDER RECORD INFORMATION
(CORI)**

Facility

Name of patient

Date of birth

I, _____, hereby authorize the release of my CORI
Name of patient
records, as obtained by this facility through the Criminal History Systems Board
on

_____, as follows:
Date CORI records received

_____ The following members of my treatment team

_____ Others

I attest to this patient's ability to understand and consent to the release of CORI information.

Date

Signature of physician

Date

Signature of patient

Commonwealth of Massachusetts
Department of Mental Health

TO BE FILED ONLY IN THE CONFIDENTIAL CORI FILE

***CRIMINAL OFFENDER RECORD INFORMATION
(CORI) REVIEW FORM***

I hereby acknowledge that I am authorized for access to inpatient CORI reports.

I have reviewed the CORI report received on _____ through the Criminal
History Systems Board relative to _____, as set forth
in DMH Policy # 01-_____.
date received
name of patient who is subject of report

Upon review, I submit the following findings:

- _____ No CORI record is currently available relative to this patient.
- OR,**
- _____ The CORI report received does not include information relevant
to the clinical risk assessment of this patient
- OR,**
- _____ The CORI report received contains information which may be
relevant to the risk assessment of this patient and further review
of the record by appropriate clinical staff may be necessary
- AND/OR,**
- _____ The CORI report received contains information relative to one or
more of the charges listed in Section D. of DMH Policy # 01-_____
and the information contained therein should be further evaluated.

The information included on this form has been conveyed to the patient's attending psychiatrist, or other designated CORI authorized clinician.

Date

Signature

Name

Title

Facility

Phone

Commonwealth of Massachusetts
Department of Mental Health

AGREEMENT OF NON-DISCLOSURE

I, _____, acknowledge that I understand the provisions of the Massachusetts General Laws, chapter 6, sections 177-178, which provide that it is a criminal offense to willfully disclose to any unauthorized person or agency any criminal offender record information concerning any individual or to willfully falsify any criminal offender record information. I further understand that I am subject to a fine of not more than five thousand dollars, or imprisonment in a jail or house of correction for not more than one year, or both, for any willful disclosure to any unauthorized person or agency of any criminal offender record information or for any willful falsification of any criminal offender record information.

Signature

Name

Agency or Business Name

Agency or Business Address

Date

This document was created with Win2PDF available at <http://www.daneprairie.com>.
The unregistered version of Win2PDF is for evaluation or non-commercial use only.